



# Psychosocial support in crisis and conflict settings

## 1. Context/challenge

Armed conflicts have not only a devastating effect on a country's infrastructure, security and economic development, but also a huge and significant impact on the psychological and social well-being of the individuals affected. A failure to recognise and deal with psychological suffering at individual and collective level has a negative and lasting impact on social cohesion and economic productivity within societies (WHO 2013).

The link between violent conflict and psychological stress is complex and often unpredictable. When we speak of someone being traumatised, we generally mean that a person has lost his or her ability to cope with everyday life due to existential experiences of fear, destruction and/or loss. A massive threat to an individual's life and identity disrupts the normal mechanisms of coping with experiences. We are talking here primarily about a once-off traumatic event. However, when it comes to conflict zones and the partner countries of international cooperation, we are often in contexts characterised by long-term conflict, poverty and social exclusion or the consequences of ongoing violence and fragility. The bulk of civilians, therefore, lives in a context of ongoing traumatisation that is characterised by repeated experiences of violence, a shattered social network, poverty and poor economic prospects. State services are frequently only partially functional, while there may be a complete lack of qualified psychological and medical personnel in many cases. Measures to raise awareness of the causes, consequences and ways of dealing with psychological suffering among the general population and professionals working for example in the health, education and social service sector are few and far between.

In this context, migration, flight and displacement are common place. Forced migration generally results in new traumatic experiences. The individuals concerned usually find themselves in insecure environments and socially and culturally unfamiliar contexts. They frequently lack sufficient care provision and experience violence, exploitation and the feeling of deprivation while their legal status is uncertain, as is their future and that of their family members.

Against this backdrop, we often speak of 'trauma as a process' or 'sequential traumatisation' (see diagram in annex) in order to highlight the interplay between socio-political and intra-psychological processes (Becker 2014; SDC 2006). The individuals concerned come to consider the absence of a safe and stable environment as normal. To come to terms with this situation, they start developing survival strategies at personal and community level seeking better prospects in life. Those, who do not succeed may frequently experience symptoms such as depression and anxiety disorders, suicidal thoughts and alcohol and drug abuse, with the associated negative impact on social relationships within and outside of families.

Given the fact that there is usually a large number of affected individuals in crises and conflict contexts, yet few opportunities for therapy, the WHO and UNHCR (2012) caution against conducting medical diagnoses at individual level across entire regions. This may risk stigmatising many people without offering them sufficient opportunities for treatment and support. Moreover, a solely medical approach moves the process of overcoming trauma from the survivors' social circles into the therapy room. This method has proven successful in societies with a well-developed medical infrastructure and comparatively small numbers of cases.

However, in countries with high case numbers, comparatively weak medical infrastructure and few qualified personnel and a prolonged insecure context this approach has limitations. Experts assume that on average one-third of the affected persons suffer from mental long-term consequences. They are in need of psychosocial support in order to develop new prospects for life in the medium to long-term. For the majority of those concerned, however, it generally is sufficient to stimulate the self-healing capabilities of the individual and of their social networks. Political processes that seek to identify and recognise the causes of trauma (truth seeking and truth telling) and to encourage social bonds and new approaches to dealing with it (giving social recognition to traumatised individuals instead of excluding them, granting them survivor rather than victim status, integrating them into the process of reconstruction in the aftermath of war) are the ones that will offer therapeutic benefits in this context. Having said that, there will always be a small percentage of people who are more severely affected and who need specialised mental health support. Both, the medical and the social/community based approach, require a deep understanding of the political and cultural context.

The vulnerability of each individual essentially depends on the type of events they have experienced, their psychological constitution and past experiences, and the current personal, social and cultural environment in which they are living. Particularly vulnerable groups include:

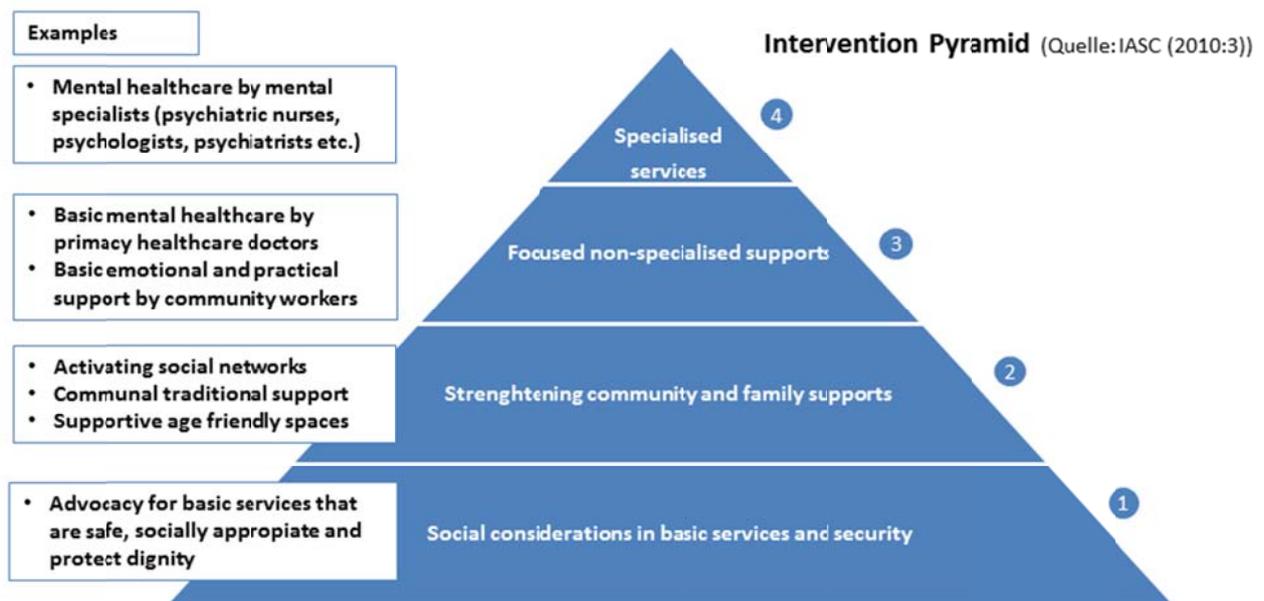
- women (due among other things to specific experiences of violence such as sexual assault, or loss of social standing, e.g. in the case of widows and single mothers);
- refugees and internally displaced persons (due *inter alia* to especially traumatic experiences on the run);

- ex-combatants (due not least to specific experiences of violence as perpetrators and victims);
- socially marginalised groups and individuals with particular needs (including disabled persons and the elderly or infirm);
- political prisoners (due among other things to torture and extreme conditions in prison);
- relatives of missing individuals (due *inter alia* to a lack of future prospects);
- children and young people (both as part of the aforementioned groups and as a separate group).

Everyday violence and armed conflict destroy social relationships and networks, which has a huge impact on gender images and roles within society. As such, it is important when working with one of the aforementioned target groups to always take into account family situation and social environment.

## 2. Approach and quality criteria

The four-layer model of the Inter-Agency Standing Committee (IASC 2007/2010) is internationally referred to as a reference for Mental Health and Psychosocial Support (MHPSS) in crises and conflict environments. It identifies four distinct layers of psychosocial support that in an ideal scenario address the different needs of different groups simultaneously and on a complementary basis (see diagram). The higher up the pyramid a form of support is found, the more specialised it is and the smaller a target group it has. Consequently, most interventions by development and international cooperation are found in the first three layers with a special focus on community-based approaches.



- The bottom layer represents the provision of basic services and the re-establishment of basic infrastructure to meet basic physical needs (food, accommodation, water, basic health care). These services are often delivered as part of humanitarian assistance and/or long-term development cooperation. This should be done discreetly and respectful, in accordance with the psychosocial needs of the individuals affected (in a ‘trauma-sensitive’ manner). Among other things, this means that the provision of these services should not give rise to a victim mentality or to stigmatisation, nor should it encourage victim-perpetrator identities. Instead, it should take account of and, ideally, boost the psychosocial well-being of the affected individuals. This can be supported through participation and making people feel in control of their situation.
- Building on this, the community and family support layer serves to strengthen local social networks, for example, by creating or consolidating secure spaces for community dialogue, promoting family reunification, assisting with mourning processes, encouraging (non-formal) educational and recreational provision, and developing employment and income-generating opportunities for groups of young people and women etc.
- In the third layer, more focused, non-specialist emotional and social support is provided to individuals, families or groups (e.g. victims of sexual violence) by trained and supervised community workers. Furthermore, the IASC also includes within this layer the provision of ‘psychological

first aid’ immediately following a traumatic experience. The IASC stresses that this is not so much a medical treatment as a form of human support for the affected individuals: being there for them, listening to them, offering consolation and protection, providing them with daily essentials, and ensuring their (professional and/or social) needs are met in future as well. This work can be undertaken by basic health care staff. However, in the context of violent conflict, this form of first aid is rarely sufficient and can only be provided to a limited extent, as the affected individuals are exposed to ongoing traumatic events and often reside in an unsafe environment.

- In the top layer, medical and psychological experts provide specialist services to individuals who are extremely limited in their ability to function properly on a day-to-day basis and who therefore require long-term psychological, therapeutic or psychiatric treatment. These individuals may be referred to see specialists. However, in countries that lack a sufficient number of suitably qualified specialists and experience high levels of everyday violence and insecurity, this approach is only to a limited extent possible. Additionally, only few individuals have access to such services. A long-term approach is, therefore, needed, along with corresponding resources, in order to facilitate the necessary initial and ongoing training of health care specialists and the provision of support for setting up referral systems.

While any post traumatic reactions and disorders only tend to develop after the traumatic events have ceased, affected individuals can be supported at each phase in the traumatisation process. Psychosocial work aims to create safe spaces within an unsafe environment, to help and stabilise individuals, and to promote social and political opportunities for addressing trauma. These, in turn, are key prerequisites for dealing constructively with conflict at family and societal level and for the long-term reconstruction processes.

In our work, we at GIZ take our lead from internationally accepted standards (IASC, WHO). The following quality criteria are especially important:

- Needs based and impartiality: support is provided to affected individuals based solely on need, with no special preference given to any one group. It is particularly important that our own activities are transparent and credible in this area.
- Conflict-sensitivity, the ‘do no harm’ principle and prevention: we carry out our work in a conflict-sensitive manner and with due regard for local context. We take into account existing conflicts at different levels and strive to de-escalate and, where possible, prevent them.
- Participation and ownership: we actively involve the affected individuals and their communities in all phases of the support process, using and building on existing expertise.
- Emancipation: the support we provide strengthens the ability of individuals to help themselves and restores their dignity while counteracting the development of a victim mentality and any sense of stigmatisation.
- Community focus: in addition to supporting the affected individuals, we also encourage societal recognition of their suffering and the addressing and processing of events, taking into account approaches to dealing with the past (cf. GIZ/transitional justice services).
- Structural support and resilience: as far as possible, all activities are integrated into the existing system. Use is made of existing potential and resources in order to achieve a longer-term impact. By supporting structural reforms, we promote the development of resilience at individual, communal and national level.
- Lasting impact: given the need for long-term processes for supporting individuals and dealing with trauma at individual and societal level, we refrain from the exclusive use of short-term relief.
- Cooperation: we pursue broad-based cooperation with state and civil society actors.

### 3. GIZ’s services

GIZ’s work is characterised by a multi-level approach that is able to combine measures at local (individual, family, community) and regional level with measures at national level (e.g. advising ministries) as required and combine rapid, short-term support with long-term structural approaches. Our work focuses on the first three IASC layers, though services can also be provided within the fourth layer where the necessary conditions are in place (for example, the right context and long-term support options).

We provide the following services:

#### a) (Re-)building of meeting and information points and basic infrastructure

In order to contribute to psychosocial stabilisation and by extension to the prevention of future trauma manifestations, it is first necessary to address the current and immediate concerns and needs of the population and to provide support for family and community reunification and the resumption of daily routines. This includes:

- setting up and coordinating information and meeting points locally,
- rebuilding and expanding community centres or religious institutions,
- and rehabilitating public institutions such as schools, health centres and youth clubs.

#### b) Raising awareness among multipliers of the basics of psychosocial support and crisis intervention and training/qualifying them for these areas

Given the large number of individuals affected and severely traumatised, as many people as possible should be made aware of and trained in the basics of how to recognise and deal appropriately with trauma:

- strengthening psychosocial support by developing, coordinating and imparting basic knowledge for identifying cases of traumatisation and dealing with traumatised individuals;
- potential target groups for this measure include all groups of professionals in direct contact with the affected population (e.g. teachers, doctors, nurses, medical workers, social workers, community and family workers, staff of religious organisations and, in a specific manner, actors from the security sector and media representatives).

#### c) Providing structural support for psychosocial support and advisory services and training for local specialised professionals

Especially in those conflict regions in which the process of addressing and dealing with trauma is a long-term individual and societal issue, it is necessary to take

into account structural support for and integration of support and advisory services in state services and the provision of initial and ongoing training to specialists:

- provision of advice and support to sector ministries regarding the design and development of psychosocial support and advisory services and their integration into existing services, especially in the areas of education, youth work and health care;
- assistance with the design and, if relevant, implementation of training courses for specialist professionals (medical specialists, psychologists, psychotherapists) in culturally adapted psychotraumatology and trauma therapy methods, in cooperation with local/international specialists and institutions.

#### **d) Developing networks**

Network development encourages specialist dialogue and with it the professionalisation of psychosocial work. It can also make a lasting contribution to reconciliation among conflicting parties:

- development and support of local networks and initiatives in the field of psychotraumatology and trauma therapy;
- promotion of specialist dialogue between local and international networks.

#### **e) Supporting peer-to-peer review and learning and establishing supervisory structures**

Professionals working in the field of psychosocial support are also exposed to the risk of becoming traumatised themselves, whether as a result of having experienced trauma in their own lives or as a consequence of empathic witnessing of traumatic events within the affected population.

- In order to prevent burnout among project staff, staff members should speak about stressful experiences in their work on a regular basis. Special preparation courses equip them to deal more effectively with stressful situations and remain stable throughout them (self-care).
- Supervision (or intervision among professional peers) can also be offered to staff of other organisations (local and international) as a standalone component (staff care). It is not only about maintaining good health among deployed staff, but also involves training on the job, as these staff are given an opportunity to engage in dialogue with experienced colleagues.

A multi-phase intervention approach needs to ensure that, in addition to standalone projects, approaches to providing psychosocial support are integrated into other types of measures in such areas as

- humanitarian aid,

- emergency and transitional aid,
- rehabilitation and crises prevention, and
- long-term development cooperation, for example, as sub-components in the sectoral approaches of infrastructure programmes and efforts to promote education, health care, training and employment.

#### 4. Examples from the field

Projects currently under way that are related to psychosocial support (as at May 2015):

groups have experienced tremendous psychosocial stress and disorders as part of their reaction to the situation. In

Project title	Country	Overall term	Total volume
Treating traumatised refugees and peace education measures (CPS)	Burundi	01.12.2014 – 31.12.2017	EUR 550,000
Psychosocial support for refugees, reintegration and peace education measures (CPS)	Rwanda	01.12.2014 – 31.12.2017	EUR 1,032,000
Support to the psychosocial advisory services for Palestinian refugees from Syria in Lebanon	Lebanon	28.08.2013 – 31.12.2017	EUR 3,450,000
Rehabilitation of Lebanese public schools with Syrian refugee children and development of school capacities, including for disadvantaged Lebanese children (ELCaps)	Lebanon	13.08.2016 – 31.08.2018	EUR 5,800,000
Peace education in Sri Lanka (ESC)	Sri Lanka	05.03.2013 – 31.03.2016	EUR 3,754,422
MHPSS in the context of the Syria- Crisis - Regional Programme	Region around Syria/Germany	01.09.2015 -30.10.2018	EUR 3,000,000
Development of a standardised psychosocial support structure at UNRWA schools in emergency and crisis situations	Jordan	08.10.2013 – 01.11.2015	EUR 250,000
Support for the Gaza Community Mental Health Programme	Palestinian territories	15.12.2012 – 31.12.2013	EUR 223,000
Promoting the reintegration of returning IDPs in their home regions in Vanni, Sri Lanka	Sri Lanka	03.08.2010 – 31.12.2013	EUR 4,200,000
Guatemala peace process support programme (PCON)	Guatemala	31.08.2001 – 07.10.2013	EUR 14,953,435
Improving the living conditions of internally displaced Iraqis and the local population in Dohuk Province	Northern Iraq	07.11.2014 – 30.06.2015	EUR 27,000,000

#### Case study *‘Strengthening psychosocial support for Palestinian refugees from Syria’*

450,000 Palestinian refugees are registered with the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) in Lebanon. Of these, 240,000 live in the 12 refugee camps run by UNRWA. As a result of the war in Syria, they have been joined by a further 45,000 Palestinian refugees from Syria. Due to the failure to resolve the Middle East conflict and find a durable solution to the Palestinian refugee issue, Palestinian refugees in Lebanon have been living in a situation of insecurity, poverty and marginalisation for over 60 years. For the Palestinian refugees from Syria, the events of the war in Syria, their experience of fleeing the country and the catastrophic conditions in Lebanon are also extremely traumatic experiences. Both

order to reach as many Palestinian refugee children and young people as possible, along with their parents, the psychosocial support work is focused on the existing structures and basic services provided by UNRWA in all the Palestinian refugee camps in which most of the Palestinian refugee community from Syria is currently seeking refuge.

The GIZ programme ‘Strengthening psychosocial support for Palestinian refugees from Syria’ involves the mainstreaming of a systemic and resource-oriented approach to psychosocial work in all UNRWA services (schools, health centres and social work) and the improvement of psychosocial services by civil society organisations in selected refugee camps. Services in the area of Mental Health and Psychosocial Support (MHPSS), further developed and improved by

the programme, are aimed at all Palestinian refugees living in Lebanon.

The goal of the project is to improve psychosocial support structures and develop new options for dealing with the ongoing crisis situation.

This is achieved by training health care staff, advisors, teachers and social workers, developing peer supervision systems and linking UNRWA services with civil society provision. In addition to local work in selected refugee camps, support is provided for mainstreaming the approach in all UNRWA programmes (health, education and social matters) at national level and developing a superordinate strategy for UNRWA. As well as facilitating temporary improvements in psychosocial care for the current crisis situation, this multi-level approach mainstreams its principles in the support structure of UNRWA, thereby helping to boost individual and institutional resilience.

## Further reading

Becker (2014 / 2nd edition): Die Erfindung des Traumas. Verflochtene Geschichten.

GIZ (2003): Entwicklungsorientierte Traumabearbeitung in Nachkriegssituationen.

GIZ (n.d.): ZFD im Fokus: Traumabearbeitung und psychosoziale Rehabilitation – der Beitrag des ZFD.

GIZ (n.d.): ZFD im Fokus: ZFD Arbeitsansatz – Vergangenheitsarbeit.

GIZ (n.d.): Leistungsangebot Transitional Justice.

Hamber et al. (2014): Narrowing the gap between psychosocial practice, peacebuilding and wider social change: an introduction to the Special Section in this issue, Intervention 2014, Volume 12, Number 1, 7-15.

IASC (2007): IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2010): Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know?

medico international (2005): Psychosoziale Arbeit in Gewaltkontexten: Konzeptionelle Überlegungen. In: Medico-Report 26.

SDC (2006): Gender, Conflict Transformation & the Psychosocial Approach.

WHO (2013): Building Back Better: Sustainable Mental Health Care after Emergencies.

WHO/UNHCR (2012): Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings.

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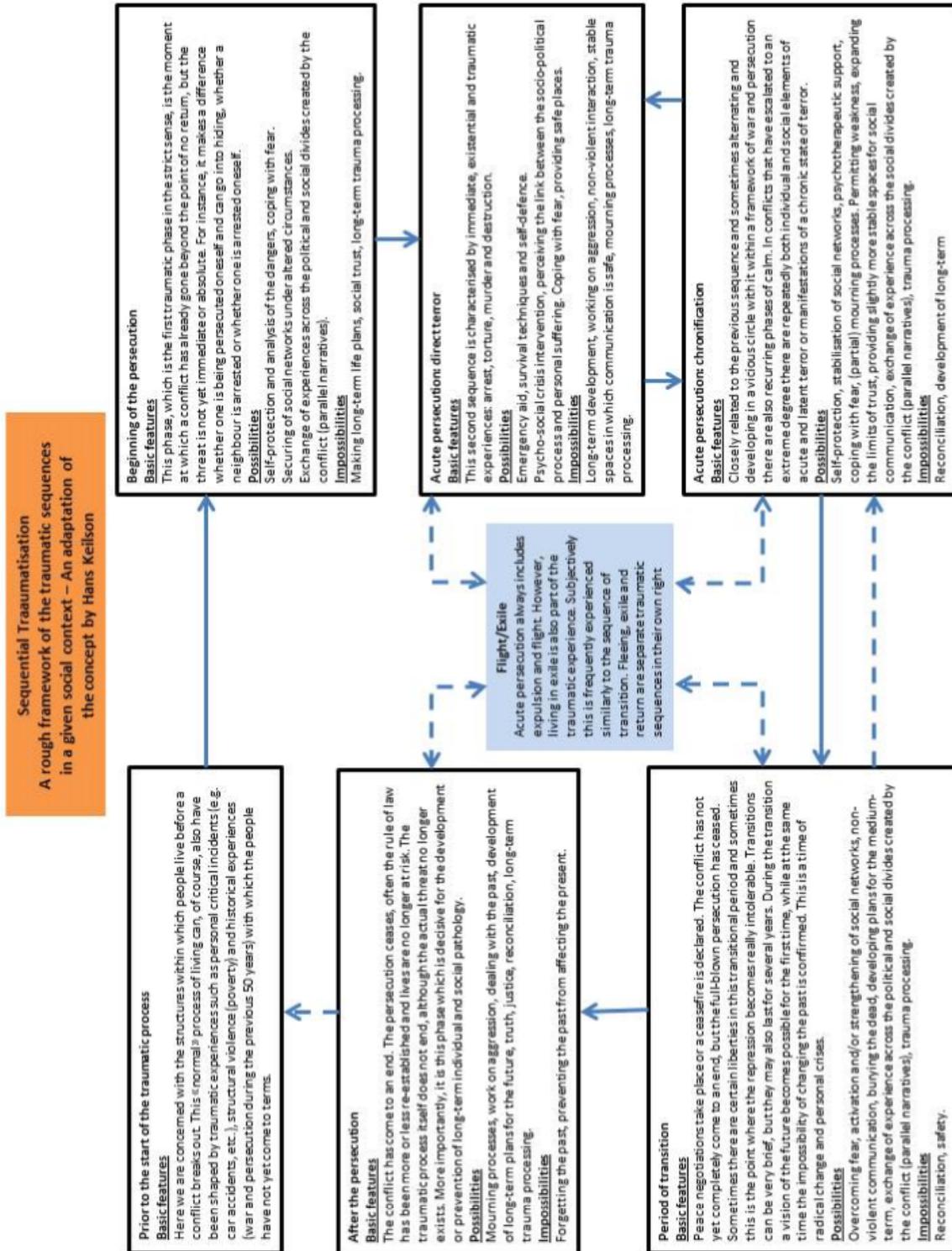
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I [www.giz.de](http://www.giz.de)

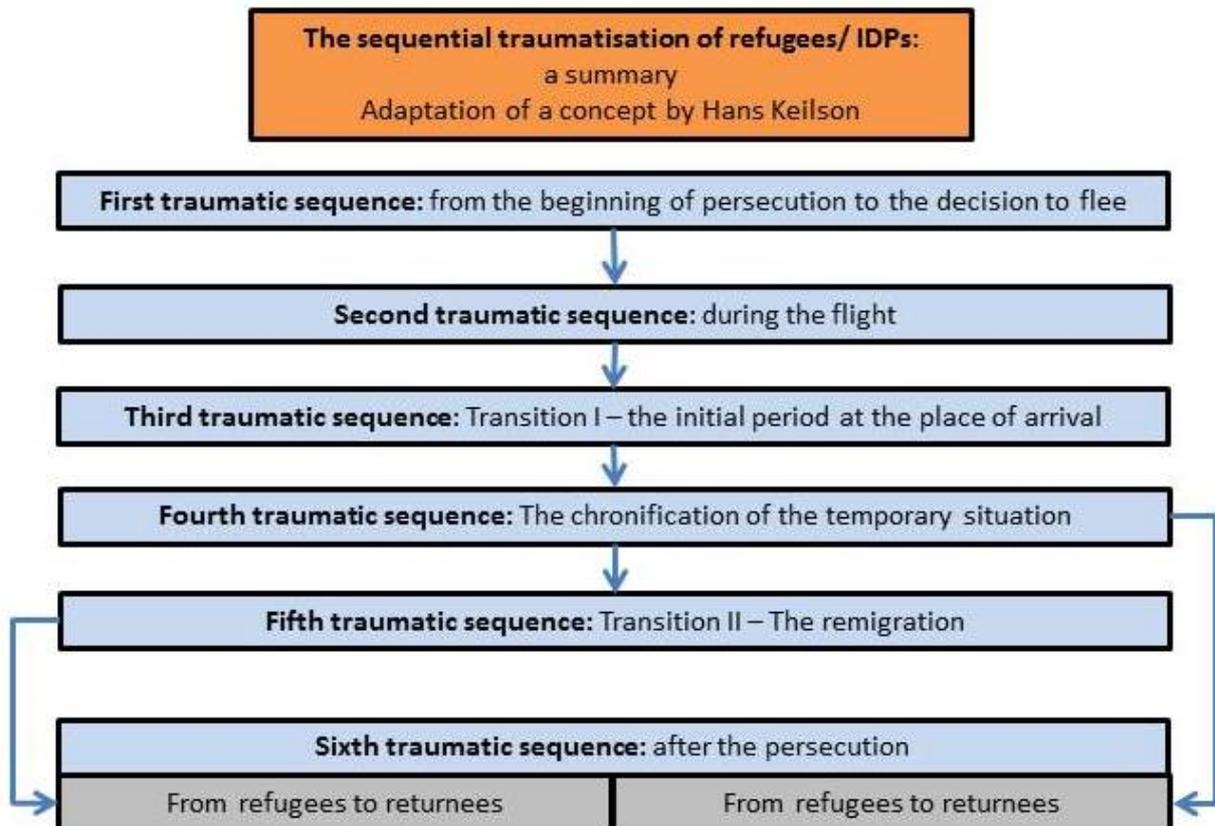
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# Annex

## Sequential traumatisation (adapted from Hans Keilson) in the context of conflict and post-conflict situations (please refer to SDC 2006: 43/44)



Sequential traumatisation (adapted from Hans Keilson) in the context of refugee situations (please refer to SDC 2006:69)



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